Maricopa Health Plan

Maricopa Health Plan (MHP) is a plan funded by CMS and administered by the Arizona Health Care Cost Containment System (AHCCCS). Services covered under this plan include, hospital care, lab work and x-rays, maternity care, behavioral health (see section 19 of this manual), medical tests, medically needed dentures, medically necessary transportation, physician office visits, prescription drugs, supplies/equipment, urgent care, checkups, emergent care, emergency medical treatment, children's services, including routine dental care, foot care as medically indicated, family planning/birth control, ambulance, emergency services emergency dental care (members over 21), eye glasses or contacts after cataract surgery, well child, including flu shots, vision/hearing exams. Services not covered under the plan are: hearing aids, eye exams for glasses for members over age 21, medical services or items not approved by your PCP or health plan, medical care provide to a person who is an inmate of a public institution or who is in custody of a state mental health facility, medially necessary oral nutritional supplements for members 21 years of age and older, medicines not on MHPs approved formulary list, non approved care for research reasons only, Outpatient, occupational therapy and speech therapy for members over 21 years of age, personal items, physical therapy ordered only to keep a patient in the present condition, routine dental care for members over 21 years of age, routine medical care out of the service area, are or items provide only for cosmetic purposes, sex change operations and changes of surgically caused infertility and infertility treatment and drugs.

NOTE: All MHP contracted providers intending to provide care to MHP members must apply for and receive an AHCCCS ID number. You can reach AHCCCS at (602) 417-7670 or write to them at: AHCCCS Administration Office, Attention: Provider Registration, Mail Drop 8100, 801 East Jefferson, Phoenix, Arizona 85034 *Remember that you can not bill or be reimbursed for services without an AHCCCS identification number. Additionally, participating Providers are required to fully participate in our Quality Management Programs, Utilization Management Programs, regulatory agency surveys, successfully complete our Credentialling process, utilize our formulary, and refer to contracted providers for specialty and ancillary services.*

Eligibility Requirements

Members must meet the financial criteria established by AHCCCS and reside in Maricopa County. To verify eligibility and benefits for members who have selected or been assigned to MHP, providers can call 602 344 8957 Monday – Friday from 8:00 am –5:00 pm. You may also fax your requests to 602 344 8933 we will return your request within 48 hours..

Enrollment

An individual may elect MHP at the time of enrollment with AHCCCS or during the period known as open enrollment. Prior to 1998 open enrollment was an annual event, at which time ALL AHCCCS members had to choose a health plan or could make changes to their existing choices. The process has been changed to allow open enrollment to occur at any time during the year. The new process is called ***Annual Enrollment Choice***. The individual's anniversary date will determine the time he/she may change health plans or stay with her/his health plan. Changes do occur off cycle for a variety of reasons, continuity of care issues being the most common. Please direct the member to Member Services regarding questions related to this process.

Quality Management/Quality Improvement

MIHS-HP contracted providers agree to participate in MIHS-HPs quality improvement processes and improvement programs. Quality Management includes credentialing, recredentialing, facility audits and active participation in surveys conducted or initiated by our regulatory agencies. Direct any inquiries regarding quality to our Quality Management Department.

Maricopa Health Plan cont.

Utilization Management

MIHS-HP contracted providers agree to participate in all aspects of its utilization program including but not limited to prior authorization, case management, discharge planning and medical review.

Formulary

MIHS-HP has a closed formulary and expects its physicians to use the drugs listed on the formulary. Should a formulary drug not be appropriate for your member, please request a non-formulary drug via fax or telephone to MIHS-HP. Requests for additions to the formulary should be directed to the MIHS-HP Medical Director. The Pharmacy and Therapeutics Committee will review requests for inclusion.

Specialty Referrals

MIHS-HP maintains a specialty network to address the needs of our membership. Please refer our members to contracted specialists whenever possible. If you are a physician in private practice and find it necessary to refer outside of our network, please be sure to complete the Outside Service Request (OSR) and fax it to our Medical Management Department for approval. Please ensure the OSR is complete and accompanied by all supporting documentation for the out of network request. Provider Services will be happy to assist you with any questions regarding this process.

Supplies

An OSR as well as a Certificate of Medical Necessity must accompany requests for supplies for MIHS-HP members. If you are a physician in private practice, please be sure to complete the Outside Service Request (OSR) and fax it to our Medical Management Department for approval. Please be sure to include all supporting documentation to ensure that there is no delay in providing medically necessary and covered items for your patients.

Dually enrolled members

Maricopa Health Plan will always be the payer of last resort. Claims must be submitted to the primary payer before reimbursement from MHP. All MHP requirements must be met even we are the secondary payor. Providers can call Provider Services at 602 344 8597 to verify eligibility and benefits Monday through Friday from 8:00 am to 5:00 pm.

Communication with Members

MHP expects that Providers will communicate with its members in a timely fashion regarding their medical care. Clear and concise communication with the member in language and manner that he/she understands regarding the risks, benefits and consequences of treatment or non-treatment, and the member's right to refuse treatment must be clearly communicated. This communication must be documented in the member's file. ***The practice must have a process in place to arrange for interpretive services if necessary.***

Maricopa Health Plan cont.

Prior Authorization

Service or Procedure	Phone Number	Fax Number
After Hours Authorizations	(602) 344-8111	(602) 344-8458
Hospitalization Requests/Notifications: Inpatient hospitalizations Pre-admissions for elective surgery Observation Unit	(602) 344-8483 (602) 344 8825	(602) 344-8348
Outpatient services: Outside of the service area provider Contracted provider	(602) 344-8480	(602) 344-8706
Skilled Nursing Facilities	(602) 344-8734	(602) 344-8348
Rehabilitation	(602) 344-8734	(602) 344-8348
OB Authorizations/Notifications: Delivery notifications Prenatal care/global OB services	(602) 344-8111	(602) 344-8458
Pharmacy: Non-Formulary Drug Request Drugs requiring prior authorization Intravenous infusion (IV) non-formulary hydration TPN (total parenteral nutrition)	(602) 344-8573	(602) 344-8858
Dental: Dental Evaluations	(602) 344-8111	(602) 344-8706
Dentures	(602) 344-8483 (602) 344-8825	(602) 344-8706
Supplies/Equipment (DME): Durable Medical Equipment	(602) 344-8483 (602) 344-8825	(602) 344-8706
Oxygen	(602) 344-8111	(602) 344-8458
Prosthetics, Orthotics, Braces	(602) 344-8483 (602) 344-8825 (602) 344-8859	(602) 344-8706
Home Care Services: Home Health Aid Home Uterine Monitoring	(602) 344-8483 (602) 344-8825 (602) 344-8859	(602) 344-8706
Home Health Care	(602) 344-8734	(602) 344-8706

Maricopa Health Plan cont.

Prior Authorization cont.

Home Health Nursing	(602) 344-8825	(602) 344-8706
Other:		
Allergy consults & testing (Outside of FHC's)	(602) 344-8483 (602) 344-8825 (602) 344-8859	(602) 344-8706
Dexa Scans	(602) 344-8111	(602) 344-8458
Dialysis	(602) 344-8111	(602) 344-8348
Dialysis – Out of Network	(602) 344-8111	(602) 344-8458
Disease Management Programs	(602) 344-8111	(602) 344-1224
Hospice	(602) 344-8483 (602) 344-8825	(602) 344-8706
Transportation/Non emergency ambulance	(602) 344-8300	(602) 344-8458
Podiatry care in a skilled setting - Non-Medicare	(602) 344-8111	(602) 344-8458
Podiatry outpatient Care	(602) 344-8111	(602) 344-8458
Nutritional supplements	(602) 344-8483 (602) 344-8825	(602) 344-8706
Pain Management	(602) 344-8483 (602) 344-8825	(602) 344-8706
Seating Evaluations	(602) 344-8483 (602) 344-8825 (602) 344-8859	(602) 344-8706
Sleep Studies	(602) 344-8483 (602) 344-8825	(602) 344-8706
Therapies: Pulmonary, Respiratory, Cardiac Rehab, OT, Speech, PT	(602) 344-8483 (602) 344-8825	(602) 344-8706
Transplants or related care	(602) 344-1811	(602) 344-1224

Certificates of Medical Necessity

A Certificate of Medical Necessity (CMN) must accompany orders for DME, services, and supplies.

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Outside Service Request
An Outside Services Request (OSR) form will be required for some services. An example of an OSR is provided on page 5.8.

In the course of arranging or providing services, you may be required to provide the following additional documentation:

Durable Medical Equipment	A signed OSR, progress notes, and/or justification for the requested equipment, and a Certificate of Medical Necessity (CMN) may be required.
Hospice	A physician order may be required.
Nursing Home Placement	One or more of the following may be requested: Current History and Physical Current medication and treatment orders Current TB test\Chest X-ray All problem lists Lab results Physician Progress Notes Any consult or therapy evaluations Immunization records
Therapy	A OSR may be requested
Specialty Providers	Information regarding the referral to the receiving provider
PCPs or Specialists	Information or reports back to the referring provider
All Providers	Communicate with all treating providers as needed when informed by Member of other treatment

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Claims Submission

MIHS-HP processes clean claims within thirty (30) working days of receipt. A clean claim contains all the elements necessary to process the claim. Claims must be submitted no later than six (6) months from the date of service to be eligible for payment. Charges for professional fees must be submitted using a HCFA 1500 form. Charges for inpatient or non-professional type services must be submitted using a UB92 form. Please note: UPIN numbers are now required with your claims submission. The claims section of this manual will provide detailed instructions on submission.

Encounter Data & Reporting Requirements

Providers of service must ensure that encounter data and reporting requirements (including medical records) are complete and accurate. AHCCCS performs a data validation study to determine utilization, accuracy, and completeness.

Emergency & Urgent Care Services

Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual, or in the case of a pregnant woman, the health of the women or her unborn child
- Serious impairment to bodily function, or
- Serious dysfunction of any bodily organ or part

Emergency services means covered inpatient and outpatient services that are:

- Furnished by a provider qualified to furnish emergency services; and
- Needed to evaluate or stabilize an emergency medical condition
- MIHS-HP expects providers to adhere to the appointment availability standards discussed in Section III of the manual. Providers should not routinely refer patients to the emergency department. MIHS-HP monitors emergency department utilization and will track and trend results. Over utilization of the emergency department could be symptomatic of other areas of the provider's practice. Provider must ensure that MIHS-HP members receive the most appropriate care in the most appropriate setting.

Urgently needed services means covered services provided when an enrollee is temporarily absent from the health plan service area (for a period of up to 12 months) when such services are medically necessary and immediately required:

- As a result of an unforeseen illness injury or condition,

Maricopa Health Plan cont.

- It was not reasonable given the circumstances to obtain the services through MIHS-HP

Note: *MHP is responsible for the cost of post stabilization care provided outside the plan, if the care was approved by MHP. MHP is also responsible if the care was not pre-approved, because MHP did not respond to the post stabilization care provider's request for pre-approval within one (1) hour after the request, or MHP could not be contacted for pre-approval.* ***Post stabilization care*** *is medically necessary, non-emergent services needed to ensure that the member remains stabilized from the time that the treating hospital requests authorization from MHP until the member is discharged, a plan physician arrives and assumes responsibility for the member's care, or the treating physician and the Plan agree to another arrangement.*

MHP expects that members will receive the most appropriate care in the most appropriate setting at the most appropriate time. Non-emergent direction of members to an emergency setting is not viewed in a positive manner by MHP. Trends identified in this area will be tracked.

Concurrent Review/Discharge Planning

MHP must ensure continuity of care and integration of services through arrangements that include, but are not limited to:

- Use of a practitioner who is specifically designated as having primary responsibilities for coordinating the member's overall health
- An ongoing source of primary care
- Each provider, supplier, and practitioner maintains a member health record within MHP standards

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Maricopa Health Plan cont.

Appeals and Grievances (other than MSSP)

MIHS-HP members may file a grievance by calling Member Services 602/344-8760 or by submitting their grievance in writing to:

Maricopa Integrated Health Systems Health Plans
Grievance and Appeals Unit
2502 East University
Suite B125
Phoenix, Arizona 85034

Providers may file a grievance by writing to the above address.

All grievances, except those regarding claim denials, must be filed no later than sixty (60) days from the date of the adverse action, decision, or policy made by MIHS-HP. Grievances regarding claim denials must be filed in writing no later than twelve (12) months from the date of the service.

MIHS-HP will make a final decision on grievances within thirty (30) days of the filing of the grievance and dispute, unless both parties agree upon an extension in writing. If on the 25th day following the filing of the grievance, it appears additional time is required to review the case; MIHS-HP will send a letter to the grievant requesting a thirty- (30) day extension. If the extension is not agreeable to the grievant, or if the grievant fails to return the letter, MIHS-HP will use the available information to make a decision within the thirty-(30) day limit. If the 30th day falls on a Sunday or legal holiday, MIHS-HP will make a decision on the following business day. A provider or member may appeal MIHS-HP grievance decision. The request must be in writing and filed no later than 30 days following receipt of the MIHS-HP decision. The written request must be sent to the above address. MIHS-HP will forward it to AHCCCS Administration for handling.

MIHS-HP will keep grievances and appeals confidential and available only to appropriate MIHS-HP regulatory staff. All information will be kept in a secured designated area of MIHS-HP and shall be retained for five (5) years following the final decision, judicial appeal, or close of a grievance.

Assessment and Treatment of Members with Complex or Serious Medical Conditions

Primary Care Physicians (PCPs) or attending physicians during outpatient, emergency or inpatient care will develop a treatment plan in coordination with appropriate medical personnel, case mangers MIHS-HP-MHP case management staff. Treatment plans must be developed for members with the following conditions:

- Transplants
- Brain tumor
- Closed Head injuries
- Myocardial infarction
- Asthma
- Ventilator dependent members
- Leukemia
- Trauma i.e. burn, amputations, spinal cord injuries
- AIDS
- Diabetes
- Sickle cell disease

Maricopa Health Plan cont.

MHP Members must be informed of specific health care needs that require follow up and must receive, as appropriate, training in self-care and other measures they may take to promote their own health. Treatment plans must be monitored on a periodic basis.

Medical Records

MIHS-HP providers and MSSP must safeguard the privacy of information that identifies a particular member. Information may be released to authorized persons only. In the case of a new MSO (Managed Services Organization) or PCP selection, medical records must be forwarded to the new PCP or MSO as soon as possible. Original medical records must only be released in accordance with Federal or State laws, court orders or subpoenas. Records must be maintained in an accurate and timely manner. Information regarding advance directives must be kept in a prominent place in the member's file. Clear and concise communication with the member in language that he/she understands regarding the risks, benefits and consequences of treatment or non-treatment, and the member's right to refuse treatment must all be documented in the member's file. Members and Providers must have timely access to records. Medical records must be maintained for at least six (6) years. The **Practice must have a process in place to set up files for patients that have not presented for treatment.** This process is to ensure Health Plan information regarding the patient will be available when the member does present. The Primary Care Provider will receive confidential Behavioral Health information from Value Options Provider(s) regarding assigned patients. As required by AHCCCS the PCP will establish a file (or medical record) when information is received form the RBHA, even if the PCP has not yet seen the assigned member

Prohibition Regarding Discrimination

MHP and HCFA require that all providers adhere to all laws regarding discrimination, including Title VI of the Civil Rights Act of 1964, The Age Discrimination Act of 1975, the Americans with Disabilities Act and any laws applicable to recipients of Federal Funds. Health care providers may not discriminate against members based on race, gender, age, or disability. Providers must agree to provide benefits in a manner consistent with professionally recognized standards of health care, including all benefits covered by Medicare.

Plan Hospitals

- Arrowhead Hospital
- Scottsdale Memorial Hospital - Osborne
- Scottsdale Memorial Hospital - Shea
- Phoenix Regional Medical Center
-Tempe St. Luke's Medical Center
-Wickenburg Regional Medical Center
-Chandler Regional Hospital
-Boswell Hospital
- Maricopa Medical Center
- Maryvale Hospital
- Phoenix Baptist Hospital -
- Mesa General Hospital
- St Joseph's Hospital
- John C. Lincoln Deer Valley
- John C. Lincoln North Mountain
- Del Webb Hospital

Plan Pharmacies

Selected Fry's Pharmacies
Selected United Drugs
Family Health Centers

Maricopa Managed Care Systems

OUTSIDE/HOME SERVICE & CONSULTATION REQUEST
Send Billing to: MMCS Claims
P.O. Box 20019, Phoenix, Arizona 85036-0019

Date:____/____/____

Member ID No.:_____

Name:_____

DOB:____/____/____ Sex:____

PID:_____

Primary Language:_____

Facility Name and/or Contact Person:

PCP:

Member's Address

Patient's Phone:

Phone Message:

FHC:

Emergency Contact Person/Phone No.:

Case Manager: Phone No.:

Vendor Name/Address:

Vendor Phone No.:_____

Vendor FAX No.:_____

Authorization No._____ Effective Date:_____ End Date:_____ Estimated Cost $_____

Service Requested/Consult: **Request for Service <u>MAY NOT</u> exceed 90 days.**

☐ Emergency ☐ Within 48 Hours ☐ 30 Days ☐ 60 Days ☐ 90 Days

DX & medical Justification for Service/Consult: Prognosis ☐ good ☐ fair ☐ poor Height_____ Weight_____

Requesting Physician:_____ Phone:_____

Attending Physician:_____

UPIN/PAS/Provider:_____

MMCS Authorization Unit Use Only:

☐ Perry vs Kelly:

Rate Code:_____ Date Verified:_____ By:_____

☐ ALTCS ☐ MSSP ☐ MCHP ☐ HS ☐ Other_____

☐ TPL_____ ☐ Policy/ID No._____

Medicare Number:_____

☐ Part A Eff Date:_____

☐ Part B Eff Date:_____

Approval Signatures:
Approved by:

Medical Director:

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0534

CERTIFICATE OF MEDICAL NECESSITY

DMERC 484.2

OXYGEN

SECTION A Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION __/___/__

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(__ __ __) __ __ __ - __ __ __ __ HICN _____	(__ __ __) __ __ __ - __ __ __ __ NSC # _____

PLACE OF SERVICE _____	HCPCS CODE	**PT DOB ___/___/___; Sex ___ (M/F); HT.____(in.); WT.____(lbs.)**
NAME and ADDRESS of FACILITY if applicable (See Reverse)	_____ _____ _____ _____	PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN NUMBER (__ __ __) __ __ __ - __ __ __ __ UPIN # _____

SECTION B Information in This Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME) | **DIAGNOSIS CODES (ICD-9): _____ _____ _____ _____**

ANSWERS	ANSWER QUESTIONS 1-10. (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply, unless otherwise noted.)
a) _____ mm Hg b) _____ % c) ___/___/___	1. Enter the result of most recent test taken on or before the certification date listed in Section A. Enter (a) arterial blood gas PO_2 and/or (b) oxygen saturation test. Enter date of test (c).
Y N	2. Was the test in Question 1 performed **EITHER** with the patient in a chronic stable state as an outpatient **OR** within two days prior to discharge from an inpatient facility to home?
1 2 3	3. Circle the one number for the condition of the test in Question 1: (1) At Rest; (2) During Exercise; (3) During Sleep
XXXXXXXXXXXXXXX XXXXXXXXXXXXXXX XXXXXXXXXXXXXXX	4. Physician/provider performing test in Question 1 (and, if applicable, Question 7). Print/type name and address below: NAME: ADDRESS:
Y N D	5. If you are ordering portable oxygen, is the patient mobile within the home? If you are not ordering portable oxygen, circle D.
_____ LPM	6. Enter the highest oxygen flow rate ordered for this patient in liters per minute. If less than 1 LPM, enter a "**X**".
a) _____ mm Hg b) _____ % c) ___/___/___	7. If greater than 4 LPM is prescribed, enter results of most recent test taken on 4 LPM. This may be an (a) arterial blood gas PO_2 and/or (b) oxygen saturation test with patient in a chronic stable state. Enter date of test (c).

IF PO_2 = 56–59 OR OXYGEN SATURATION = 89%, AT LEAST ONE OF THE FOLLOWING CRITERIA MUST BE MET.

Y N D	8. Does the patient have dependent edema due to congestive heart failure?
Y N D	9. Does the patient have cor pulmonale or pulmonary hypertension documented by P pulmonale on an EKG or by an echocardiogram, gated blood pool scan or direct pulmonary artery pressure measurement?
Y N D	10. Does the patient have a hematocrit greater than 56%?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: _____ TITLE: _____ EMPLOYER: _____

SECTION C Narrative Description of Equipment and Cost

(1) Narrative description of all items, accessories and options ordered; **(2)** Supplier's charge and **(3)** Medicare Fee Schedule Allowance for each item, accessory and option. *(See instructions on back.)*

SECTION D Physician Attestation and Signature/Date

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE _____/_____/_____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

SECTION A:	**(May be completed by the supplier)**
CERTIFICATION TYPE/DATE:	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED **or** RECERTIFICATION date.
PATIENT INFORMATION:	Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.
SUPPLIER INFORMATION:	Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).
PLACE OF SERVICE:	Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.
FACILITY NAME:	If the place of service is a facility, indicate the name and complete address of the facility.
HCPCS CODES:	List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN.
PATIENT DOB, HEIGHT, WEIGHT AND SEX:	Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.
PHYSICIAN NAME, ADDRESS:	Indicate the physician's name and complete mailing address.
UPIN:	Accurately indicate the treating physician's Unique Physician Identification Number (UPIN).
PHYSICIAN'S TELEPHONE NO:	Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.
SECTION B:	**(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the treating physician.)**
EST. LENGTH OF NEED:	Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.
DIAGNOSIS CODES:	In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).
QUESTION SECTION:	This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.
NAME OF PERSON ANSWERING SECTION B QUESTIONS:	If a clinical professional other than the treating physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.
SECTION C:	**(To be completed by the supplier)**
NARRATIVE DESCRIPTION OF EQUIPMENT & COST:	Supplier gives **(1)** a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs; **(2)** the supplier's charge for each item, option, accessory, supply and drug; and **(3)** the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.
SECTION D:	**(To be completed by the physician)**
PHYSICIAN ATTESTATION:	The physician's signature certifies **(1)** the CMN which he/she is reviewing includes Sections A, B, C and D; **(2)** the answers in Section B are correct; and **(3)** the self-identifying information in Section A is correct.
PHYSICIAN SIGNATURE AND DATE:	After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.